Life & Times

Psychological mislabelling in chronic pain:

reducing the risk

INVALIDATING PATIENTS WITH PSYCHOLOGICAL INNUENDO

GPs devote much of their clinical time to chronic pain. Back, joint, and musculoskeletal pain consistently rank among the top five reasons for visiting a doctor.[1] One of the pitfalls in treating chronic pain is the tendency to over-psychologise, a practice I call psychological mislabelling.[2] Psychological mislabelling occurs when anxiety, depression, and stress are routinely assumed to play a major role in cases of back pain, headache, fibromyalgia, and other poorly understood chronic conditions.

When we invoke the biopsychosocial model (BPSM) — particularly the psychological component — selectively in chronic pain, we are likely mislabelling. When we think of the BPSM only when confronted with patients we find difficult, inconsistent symptoms, or failed therapies, we perpetuate the misconceptions of a discredited psychogenic era.

Today, the standard psychosomatic handbook no longer ascribes a psychological cause to arthritis, hay fever, tuberculosis, hypertension, diabetes, or any of the other psychogenic disorders of the 1950s.[3]

And yet, the invalidation of patients through psychological innuendo continues to:

'... pollute the therapeutic relationship by introducing an element of mutual distrust as well as implicit, if not explicit, blame ... demoralising the patient who feels at fault, disbelieved, and alone.'[4]

Undermining of the doctor–patient relationship through misuse of the BPSM carries a special irony in primary care. GPs were among the earliest and most enthusiastic supporters when the BPSM was introduced in 1977 as a means of improving the therapeutic alliance.[5] Such is the allure of an overtly psychological medical model.

FREUD'S LEGACY

The overemphasis on psychological explanation is a legacy of a deep-seated psychogenic bias that ran through medicine for much of the last century. Freud developed the psychogenic model in the 1880s.[6] At the centre stood a psychological gatekeeper whose job was to regulate the entry of anxiety-provoking thoughts into consciousness. Freud believed such thoughts, frequently sexual, exerted continual pressure for conscious expression.

Occasionally, through a process of psychic transmutation — Freud's 'mysterious leap' — these thoughts would break into consciousness not as thoughts, but as physical symptoms. This was conversion. And for the next 100 years the idea that highly charged emotions could metamorphose into physical signs and symptoms mesmerised both medicine and popular thought.

CHRONIC PAIN IS BIOLOGICALLY BASED

Advances in pathophysiology, pharmaceuticals, and medical behavioural therapies started to erode the concept of psychogenesis in the middle of the 20th century. Gradually, behavioural therapy became an integral component in a new approach to chronic pain.

In the hospital-based pain centres that blossomed in the 1980s, for example, multidisciplinary teams helped patients replace opioids with non-addictive medications and behavioural self-management techniques. Importantly, the assumptions of the biobehavioural approach offer a buffer against psychological mislabelling.

Foundational assumptions of biobehavioural treatment are that: chronic pain is biologically based; a nonresponse to medical or physical therapy is not an indication of psychological involvement; and biobehavioural pain management is not psychotherapy — it typically focuses on acquiring coping skills to pace activities, increase productivity, avoid flares and triggers, and optimise medication use, rather than on emotional concerns. This is not to suggest that biobehavioural therapy is indifferent to anger, depression, personality disorders, and the like; only that when psychopathology is present it is treated as comorbid to the patient's pain condition.

Reassurance on these fundamental points can be therapeutic for patients who have been demoralised by the suggestion, implicitly or explicitly, of an underlying psychological problem. It can also set the stage for behavioural counselling by the primary care provider, or referral to a multidisciplinary pain centre or behaviourally oriented pain specialist.

Alignment of patient and practitioner perspectives around a biobehavioural model reduces the risk of psychological mislabelling while strengthening the therapeutic alliance. It is a pain management asset that should not be underestimated.

Howard B Pikoff,
Retired Pain Management Psychologist at the State University of New York at Buffalo, Buffalo, New York.

Email: pikoff@buffalo.edu

DOI: https://doi.org/10.3399/bjgp20X707525

REFERENCES

1. St Sauver JL, Warner DO, Yawn BP, *et al.* Why patients visit their doctors: assessing the most prevalent conditions in a defined American population. *Mayo Clinic Proc* 2013; **88(1):** 56–67.
2. Pikoff HB. A study in psychological mislabelling: the rise and (protracted) fall of psychogenic fibromyalgia. *Int Musculoskelet Med* 2010; **32(3):** 129–132.
3. Levenson JL, ed. *The American Psychiatric Publishing textbook of psychosomatic medicine: psychiatric care of the medically ill.* 2nd edn. Washington, DC: American Psychiatric Publishing, 2011.
4. Katz J, Rosenbloom BN, Fashler S. Chronic pain, psychopathology, and DSM-5 somatic symptom disorder. *Can J Psychiatry* 2015; **60(4):** 160–167.
5. Smilkstein G. The biopsychosocial model: whose legacy? *J Fam Pract* 1982; **15(4):** 811–812.
6. Breuer J, Freud S. *Studies in hysteria.* Washington, DC: Nervous and Mental Disease Publishing Company, 1936.

"When we think of the BPSM [the biopsychosocial model] *only when confronted with patients we find difficult, inconsistent symptoms, or failed therapies, we perpetuate the misconceptions of a discredited psychogenic era."*